



Women's Reproductive Health Rights in Poland. Between a Druggists' Conscience Clause and Their Legal Duty to Provide Contraceptives



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Abstract: This article recommends the promotion of moral competence in the health and pharmacy professions to enable them to respect human and patient health rights with a focus on the provision of reproductive and sexual health care services. In certain cultures, health care and drug providers follow their conscientious objection (conscience clause) and decline to perform specific health services, including the provision of legal contraceptives in cases protected by legal and human rights. Such malpractices may violate patients' and purchasers' legitimate rights. The article also presents findings obtained in Poland with N=121 women experimentally interviewed to examine their experiences as contraception purchasers, to assess their preference concerning facing human vs. robotic pharmacists, to manage the risk of refusal argued by the conscientious objection, and to score their moral competence with one of the dilemmas included in the MCT by G. Lind. This study demonstrated that purchasers with higher C-score (C for moral competence) would not just prefer a robotic pharmacist without a 'conscience' but, rather, a competent sales staff able to instruct the patient and advice her on any related queries. It further results that participants with higher moral competence are thus less likely to trust the medical expertise of artificial intelligence. We conclude that public institutions in pluralistic societies must manage normative reproductive health contexts more inclusively, and the election, education, and practice of health professionals in the public health care sector require the development of a normative mindset toward respecting the rights of all patients instead of respecting them selectively at the diktat of particularistic conscience.

Keywords: Conscience clause; access to legal contraception; reproductive and sexual human rights; women's rights; Moral Competence Test; thought experiment.

1. Reproductive and Sexual Health in Terms of Human Rights

Reproductive and sexual health are aspects of human health, as one of the core public and global values¹. These values, as well as the corresponding, reproductive healthcare and equal access to its services, were for the first time articulated and proclaimed in the Cairo Declaration on Population and Development (1994). The latter urges governments “to help support the provision of reproductive health and family planning services as widely as possible. We further urge Governments to ensure that all population and development policies and programmes in our countries safeguard internationally recognized human rights” (Cairo Declaration, cf., § 4).

It is further declared that “the empowerment of women and the improvement of their political social, economic and health status are highly important ends in themselves. Reproductive and sexual health is related to multiple human rights, including the right to life, the right to be free from torture, the right to health, the right to privacy, the right to education, and the prohibition of discrimination” (United Nations Human Rights). Not only equal rights, but also reduction of maternal mortality rates and decreasing the risks related to abortion (“a major public health concern for women all over the world,” according to § 6), sexual violence, unplanned pregnancies, and untreatable diseases, all belong to the scope of ‘the new generation’ human rights with their focus on contraception accessibility (Rudolf 2016), provision and distribution supported by social consensus, legal rights and governmental policies.

Further, individual reproductive and sexual health represent *public health and wellbeing* conceptualized by public health ethics (according to *The Oxford Handbook of Public Health Ethics*) as noninstrumentalizable. Human rights belong to general moral principles so that to be properly ranked, recognized, and respected, a high-type moral orientation (Lind 2019) and the ability to make a “principled” moral judgment must be developed in people. Occasionally named ‘postconventional’ in Kohlberg’s approach, general principles can be universalized consensually by public democratic discourse as a modern “faculty of principles,” as Habermas puts it. Principles remain “accumulated in postconventional discourses of justification” (Habermas 2003, 275). Accordingly, an advanced stage of conscience development would be “principled conscience” (Stage 6 in terms of Kohlberg), able to manage conflicts between human rights (fundamental rights, respectively) and particular contents, specifically these of particular conscience (e.g., Drozd 2013; Merks et al. 2015; Erstad 2019; Flynn 2008; Wicclair 2006; Nelson 2005; Yoder 2007; Curlin 2004).

“Violations of women’s sexual and reproductive health rights are often deeply engrained

1 This article is an extended and revised version of „Health vs. Conscience Clause: Examining Access to Contraceptives and the Observance of Women’s Reproductive Rights in Poland,” originally published in the *Journal of Public Value* 1(2021):153–164. In addition, the research findings were reported at three international conferences on the basis of peer-reviewed submissions: “Fair Medicine and Artificial Intelligence: Chances, Challenges, Consequences”, Tübingen, 3-5.03.2021; “The Korea Association for Public Value (KAPV) International Conference on Public Values”, Seoul, 25.03.2022; American Educational Research Association (AERA) International Annual Meeting: “Accepting Educational Responsibility”, Washington D.C., 8-12.04.2021.

in societal values pertaining to women's sexuality. Patriarchal concepts of women's roles within the family mean that women are often valued based on their ability to reproduce" (CEDAW § 16). CEDAW "guarantees women equal rights in deciding freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights," including access to contraception. "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (cf.) which might not be obvious for subjects with insufficient moral competence, rather than being due to their moral or religious affiliations.

It was one of the characteristics of modernity to take health out of the confines of religion and charity and make it a key element of action of the state and the rights of citizenship. The process, initially within the context of the constitution of the nation state, today needs to go global as a key dimension of global justice. Global health needs to move out of the charity mode of bilateral aid and philanthropy into the realm of rights, citizenship, and a global contract (Kickbush 2004, 631).

We then suggest that both the violation of fellow citizens' human rights and core values, as well as meeting an equilibrium or a reasonable disagreement (Wilkinson et al. 2016) between the subject's own vs. fellow subjects' principles, may depend on the subjects' moral competence scores, but remains unrelated to the subjects' moral or religious opinions (Mishtal 2009). This may apply to health and pharmacy professionals.

2. The Janus Face of Conscience

In the history of philosophy, theology, and psychology, the concept of conscience has had opposed connotations, ranging from subjective, irrational certainty as opposed to reasoning in terms of objective and universal norms (as in the case of Sophocles' *Antigone*) to the inner instance of independent judgment ("tribunal of conscience" and "the inherent judge of oneself" in Kant), the tension between "id" and "superego" according to Freud, and, finally, a faculty for judgment that can be socialized, that is, evolve from the particular certainty to more universal justifications of its judgments. According to Hegel,

Conscience expresses the absolute right of subjective self-consciousness, namely, to know (...) what is right and duty and to acknowledge nothing but what it thus knows to be good while asserting that what it thus knows and wills is in truth right and duty. As this unity of subjective knowledge and that which is in and for itself, conscience is a sanctuary, and that would be sacrilege to touch it. However, if the conscience of a particular individual is in accordance with this idea of conscience, if what it holds to be good (...) is really good, this can be seen only from the content of this desire for good. In turn, what is right and duty, as in and of itself reasonable (...), is essentially not the individual's proper interest (...) For this reason, the state cannot recognize conscience in its original form (Hegel 2009, § 137).

Conscience is not always satisfied with verdicts in the field of a subject's private conduct outside the public-institutional sphere. It may pretend to the overall validity of its verdicts and hence show dictatorial inclinations. This, in turn, would undermine the foundations of a modern, pluralistic society and its public institutions, as well as position such claims for validity at the antipodes of the "principled conscience" advocated by Kohlberg (and implicitly by Habermas).

This subjectivity, as the abstracted self-determination and pure certainty only of oneself, volatilizes all determinacy of right [and] duty (...) manifesting here just as a judgmental power to determine (...) from itself only what is good and what is not good (...) [This type of] Conscience (...) is par excellence that of being on the verge of turning to evil. (Hegel 2009, § 138 – § 139; square brackets added).

However, this does not imply that modern individuals are deprived of the right to their conscience. Although the right to conscience freedom is not, in Luhmann's words, a 'supra-positive right from the otherworld', it has been included in the human and fundamental rights list. "Everyone has the right to their conscience" (Luhmann 1965, 261), which finds justification in Hegel's "philosophical jurisprudence":

Morality, ethical life, and state interest [including the Rechtsstaat – K.C. et al.] (...) are each distinctive right since each form is a determination and reality of freedom. They can only collide insofar as they stand on the same line of being rights; if the moral standpoint of the spirit were not also a right and freedom in one of its forms, it could not come into collision with the right of personality or another (Hegel 2009, § 30).

Further,

In this my deepest and most personal certainty, where my belief has its origin and locus, I am free for myself against others [*bin ich frei für mich gegen andere*], and the sort of belief or other grounds, be they emotional or reflective, is irrelevant here [*sind hier gleichgültig*] (...) After all, there is an essential distinction between this very inward location of conscience, in which I remain with and for myself [as a moral subject – K.C. et al.], and its content (Hegel 1993, 337).

This content can be of various normative qualities – not necessarily equal to the principles most universally accepted, but instead rooted in the beliefs limited to a specific confession, tradition, culture, etc.

Indeed, if employees of public institutions such as public health care would like to be governed by the verdict of conscience when their duty from the legal and professional-ethical perspective is to honor the rights of the patient, then the right of morality and the statutory law of right would 'stand on the same line' and collide one against another (see also McGraw 2010). There are several solutions in this respect, ranging from the fact that prospective medical professionals will not choose a branch in which they could face conflicts of conscience up to the invalidation of the conscience clause by associations of medical professionals as contrary to the professional medical ethos (e.g., Stahl & Emanuel 2017) which would accelerate the amendment on the law. In certain countries,

it is regulated in the following way: health providers can exercise their right to conscience clause under the condition that they or their medical facility's management direct the patient to alternative providers of the relevant health services (e.g., Kane Tiernan 2021). Frequently, this involves urgent, even life-saving health care services. Such a solution results from the physician's and medical facility's information obligation toward the patient, who has the right to be informed. Further, there would be also an option to perform as a "double self-identity," (Orr et al. 2021) which is an illusory solution.

3. Conscience Clause for Pharmacists as One of the Human and Fundamental Rights

Two types of conscience clause (conscientious objection, conscientious objector, opt-out choice) were distinguished: 1) Negative: if a health care provider acts illegally (against legal regulations, e.g., against a patient's consent or rights) (this is a criminal act under article 192 of Criminal Law in Poland); and 2) Positive: if a health care provider refrains from action and follows their conscience (Kubicki 2008).

Conscience clauses for medical professionals (including pharmacists) have a strong international normative background. The American Convention on Human Rights (Article 12, "Freedom of conscience and religion") claims that "Everyone has the right to freedom of conscience and of religion" (compare Puppincck 2017; Mishtal 2009; Major 1992). The European Charter of Fundamental Rights (2000, Article 10, "Freedom of thought, conscience and religion") claims that "1. Everyone has the right to freedom of thought, conscience and religion. This right includes freedom to change religion or belief and freedom, either alone or in community with others and in public or in private, to manifest religion or belief, in worship, teaching, practice and observance. 2. The right to conscientious objection is recognised, in accordance with the national laws governing the exercise of this right." This right corresponds to the right in Article 9 of ECHR in accordance with Article 52(3).

Certain scholars unambiguously advocate for "protecting right of conscience for pharmacists" which means "protecting this right for everyone" in pluralist and democratic contexts; "if this right can be taken away from pharmacists, it can be taken away from anyone," Rudd stresses (Rudd 2007, 1904; see also Herbe 2002). The conscience clause for pharmacists is practiced in Canada, USA (e.g., Arizona, Illinois and Wisconsin (Achey & Robertson 2021; Erstad 2019; Bradley 2009; Yoder 2007; Wicclair 2006; Nelson 2005). United Kingdom and Poland belong to the group (Radlińska & Kolwitz 2015; Merks et al. 2015). Thus, the domestic right of medical professionals (including pharmacists) to a conscience clause has a solid foundation in human and fundamental rights.

It deserves to be emphasized that not every refusal to sell medicinal products is conditioned on a pharmacist's conscience clause. According to the Polish Pharmaceutical Bill of 2001, § 95, pharmacists may refuse the dispensation of medicinal products for

various reasons, for example, when the patient's life or health can be put at risk, when medicinal products can be used for non-medical purposes, when the prescription might be manipulated (not authentic), when the customer is a child under 13 years, *etc.* Furthermore, a pharmacist is free to follow their personal conscience, therefore, to refuse the provision of contraceptives according to extra-legal normative criteria. Pharmacists' Code of Ethics of 2012, § 3 is one of them. To date, pharmacists' conscientious objection has yet to be given a statutory basis. Nevertheless, in 2017 the Ombudsman of the Republic of Poland received a response from the Minister of Health that "the lack of relevant legal provisions regulating the practice of the pharmacy profession is not sufficient premise to conclude that pharmacists cannot claim the 'conscience clause'" (source: <https://bip.brpo.gov.pl/pl/content/minister-zdrowia-farmaceuci-mog%C4%85-stosowa%C4%87-klauzul%C4%99-sumienia>). Further, in 2021, BAS (the Polish Research Office)

has positively evaluated a draft law that would introduce a conscience clause for pharmacists and owners of drug stores. According to the law elaborated and delivered by the Federation of Polish Catholic Pharmacists, they will have the rights 1) to refuse to sell drugs should they be incompatible with their conscience, and 2) not to order such drugs. In practice, only procreation-related medicines are in contradiction to the conscience clause. Therefore, the law is supposed to restrict access to contraception, thus breaching women's reproductive rights. (...) The draft law provides one exception – medicaments must be given out when customer's life or health is threatened. Independent experts, however, argue that the draft law is a legal nonsense (source: <https://astra.org.pl/1574-revision-v1/>).

Thus, the following situation actually comes into play in Poland: there is no explicit legislation on the conscience clause for pharmacists, yet it is not at all uncommon for pharmacists to use the conscience clause. This finds three extra-legal bases: (1) Pharmacists' Code of Ethics of 2012, Article 3; (2) the 2017 opinion of the Minister of Health encouraging pharmacists to use the conscience clause in spite of the lack of relevant legislation; (3) Developed in 2014, the *Declaration of Faith of Catholic Physicians and Medical Students on the Subject of Human Sexuality and Fertility* (to date, several thousand medical professionals and students have voluntarily signed it).

This situation raises practical consequences that are troublesome for persons entitled to purchase contraceptives and challenges their legal and human rights with regard to health (more precisely, reproductive and sexual health). Likewise, as in health care (especially in gynecology), directing a patient with a prescription to another pharmacy to dispense prescribed drugs is viewed as complicity in an act reprehensible from the perspective of pharmaceutical conscience. Some pharmacists regard contraception as one of the methods of pregnancy termination, instead of prevention. Piecuch et al. (2014) conducted a research study with $N = 126$ Polish pharmacists. Of them,

8% (...) admitted they had refused to fill a prescription due to their beliefs, while in the opinion of 15%, they would exercise the right to conscientious objection if it were legally sanctioned. This difference may imply that about 7% of the participants sometimes dispense medications against their consciences. A relatively high rate

(17%) of participants who could not clearly state whether they would apply the conscience clause in their job if it were legally sanctioned may be explained in terms of situation-specific reaction. Those participants may have never experienced a direct conflict of conscience but they do not exclude it in the future (Piecuch et al. 2014, 314).

Not only hospitals and clinics, but also pharmacies may rise serious “concerns about the nature and future of Polish democratization” process (Zielińska 2000). Facing this, we decided to conduct a pilot study to examine how it looks from the perspective of female customers and their experiences with the pharmacists' conscientious objection.

4. Research Design, Method and Sample Description

The questionnaire “Pharmacy or a Drug Dispensing Machine?” with 37 items was developed for and addressed only to females, while excluding males and persons who do not identify as female; the sex rubric included options for ‘female’ or “person who identifies as female’ as eligible for female pharmacological contraception use (Cartwright & Nancarrow 2022). Its subject was the experience of purchasing pharmacological contraceptives intended for females and available only by prescription (excluding any nonpharmacological means, e.g., sterilization, condoms, etc.) by female purchasers. Specifically, the research was designed to examine how many female subjects entitled to purchase female contraceptives confronted a pharmacist's conscience-related obstacles when trying to purchase contraceptives. This characterization of the study group gives the study the qualification of women studies (not gender studies). Further, ½ of the Moral Competence Test developed by Georg Lind (the Workers' dilemma only; Polish MCT version was validated by Nowak et al. and certified by G. Lind in 2009) with 6 proarguments and 6 counterarguments to rank (on the Likert scale -4 to 4) was experimentally included. The questionnaire was uploaded to the e-platform Survio.pl. A pilot study with adult female participants was conducted on February 2021. The entire data set was additionally peer-reviewed and processed according to Lind's algorithm. The study carried out was pilot and exploratory in character.

A final total $N=121$ women randomly completed the survey. Only female participants were addressed, as usually it is females that are engaged in contraception purchase and are facing restrictions of their rights; 98.35% were females and 1.65% identified themselves as females; aged from 21 to 62. Educational background: 86.78% of participants with a university diploma; 9.09% of university students; 4.13% of participants with a high school leaving certificate. Demographic description: only Polish nationality, 96.6% of them being residents of Poland, 3.4% of Poland and third countries. Residential locality size: 82.3% living in cities > 100,000 inhabitants; 17.7% in smaller localities.

5. Findings

A total of 80.17% of the female population in Poland (with higher education diplomas) are purchasers of contraceptives; 19.83% are not. Contraceptives' purchasers among the most religious participants: 39.67%. 34.0% of the most religious participants are regular purchasers, 23.4% are irregular purchasers, 42.5% are not purchasers or purchase for curative purposes only. 70.25% of all participants purchase contraceptives at local ('next door') pharmacies. Most probably, they are familiar with the pharmacists, which may reduce the risk of refusal on the basis of conscientious objection.

8.96% of participants (who have ever tried to purchase contraceptives) faced a refusal based on a pharmacist's conscience clause. On the question "Should pharmacists be entitled to refuse to sell contraceptives to legal purchasers?" 88.43% answered "No," while 9.09% answered "Difficult to say." Only 2.48% marked the answer "Yes." The participants demonstrated self-awareness concerning their right to reproductive and sexual health as *at least potentially* colliding with pharmacists' conscientious objection.

As a part of the survey, the participants were presented the alternative of a 'human' vs. a 'robotic' pharmacist providing contraception. They were invited to a thought experiment participation. 67.77% of the participants welcomed artificial pharmacists, since they cannot raise a personal moral conscientious objection. However, personal preferences regarding contraception purchase and on being clients at robotic pharmacies were lower. Only 39.67% of participants showed their willingness to buy contraceptives for their personal purpose from AI. On the question, "Should an automatic pharmacist also give medical advice and recommendations, for which it is hard to ask a *human* pharmacist or even a doctor? (e.g., as a printout together with a receipt)?," the following answers were collected:

	N=121	%
Yes (= unlimited trust)	N=23	19.01%
Yes, but it is better to additionally ask a pharmacist/doctor for medical recommendations (= limited trust)	N=62	51.24%
No (= zero trust)	N=23	19.01%
Difficult to say / N/A	N=13	10.74%

Figure 1: Participants' trust concerning a 'robotic' pharmacist.

Furthermore, one-dilemma ($1/2$ MCT)-based scoring of participants moral competence was experimentally conducted. The more demanding dilemma of the "Doctor" was not used to avoid associations with medical life-and-death contexts, as between October 2020 and present time, abortion, contraception, euthanasia, etc., are constant issues in street protests, ideological battles, and human and women's rights campaigns in Poland, so a more neutral dilemma was considered to be exceptionally suited for use in our pilot study. Its validity according to moral orientations' criterion in Kohlberg's and

Lind's sense was confirmed. Though we should note that the moral competence score "C" must be a mean value for both dilemmas, one of them more, and one less challenging test participants' moral cognitive processes and their emotions. Dealing with moral dilemmas results in emotional and cognitive dissonance, and dealing with the latter might be demanding for subjects.

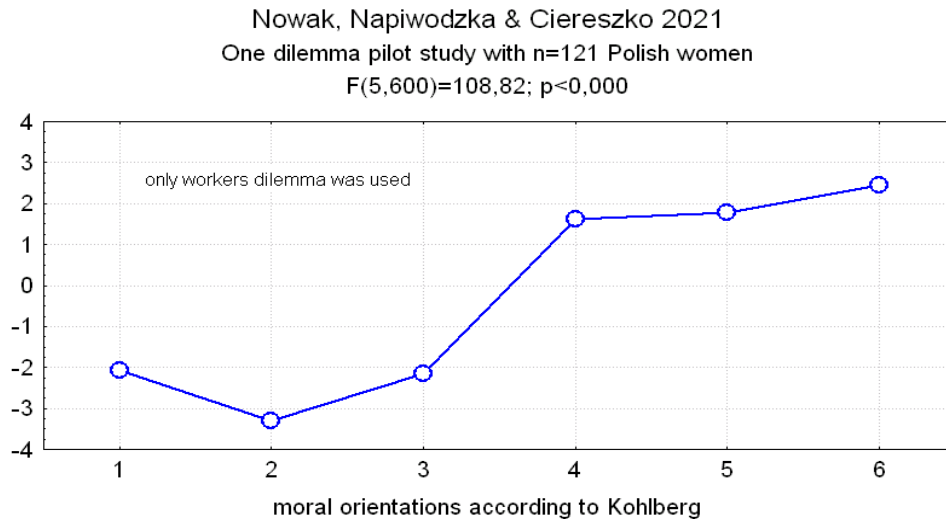


Figure 2: Moral orientations according to Kohlberg. Orientation 6 corresponds to 'principled conscience' and is represented in MCT by four arguments. Participants tend to rate their normative quality superior.

Moral competence is defined as a personal ability to make judgments, decisions, or arrive at solutions to a problem (e.g., conflict, dilemma) based on self-chosen and internally prioritized moral principles, and to act accordingly. The C-score may range between 0-100 points (Lind 2019). Below we present the correlations between participants' C-scores and their behaviors as 1) regular, 2) irregular, and 3) therapeutical purchasers and users of contraception. Interestingly, regular purchasers' C-scores are lower than the C-scores of irregular and therapeutical purchasers. The differences are partially significant (not lower than 8 C-points). However, these are approximate and incomplete values, as the full "C" (for two dilemmas) would hypothetically be lower than the "C" measured for the "Workers' dilemma" in the present pilot study.

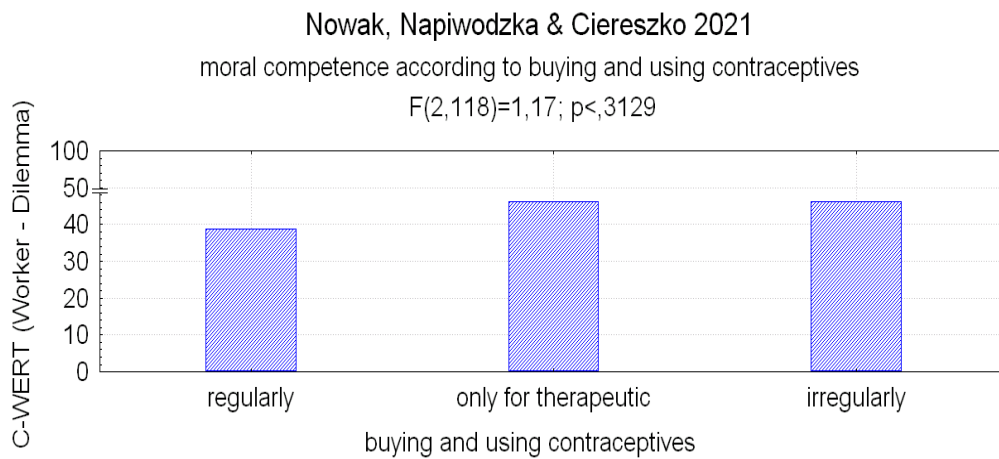


Figure 3: Buying and using contraceptives in correlation with participants' C-score.

Further, participants with higher 'half' C-scores are more likely to mistrust (or are undecided), while those with lower C-scores are more likely to trust in artificial pharmacists as competent advisers in reproductive and sexual health related issues. The difference between "Fully trusting" and "Undecided" participants in terms of their "C" (for moral competence) was significant. It suggests that participants with higher moral competence are less likely to risk their health due to robotic devices replacing medical and pharmacy professionals.

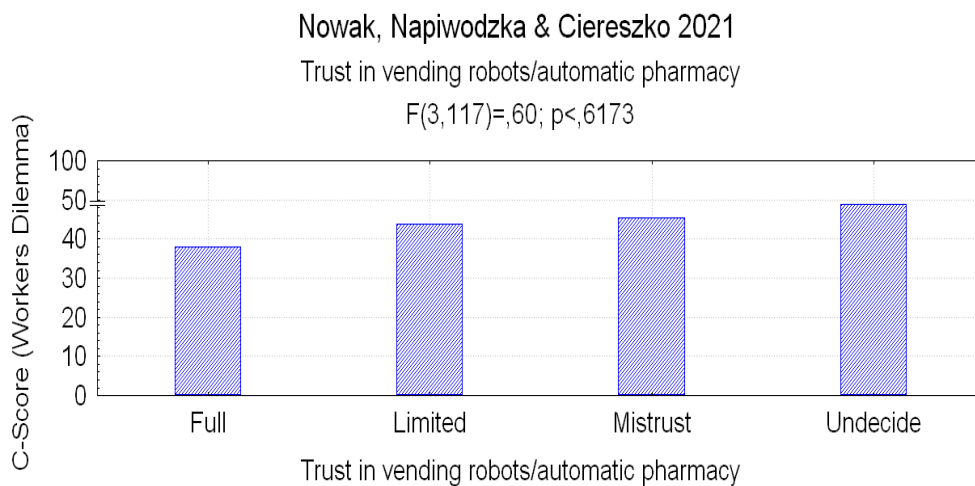


Figure 4: Participants' trust in robotic pharmacy in correlation with C-competence.

Additionally, we present C-scores measured in 2020 in Polish healthcare students (Nowak et al. 2021) for both of dilemmas, with the same instrument (Moral Competence Test). The following table shows that healthcare students achieve sufficient "C" (higher than the minimum 20 C-points recommended by G. Lind) to manage typical sociomoral conflicts and normative controversies. However, conflicts between high-type orientations such, as principles, might be still challenging when subjects have to deal with conscientious objection.

	N	Main C-score	Minimum C-score	Maximum C-score	Standard deviation
Workers' dilemma C-score	115	44,61516	4,5455	91,95876	23,62329
Doctor's dilemma C-score	115	40,93825	19,3182	92,08791	26,76602

Figure 5. C-scores of Polish healthcare students (Nowak et al. 2021).

Conclusions and Discussion

The presented findings demonstrate that contraception purchasers and users are usually aware of the normative conflicts between such high-type, general, human rights-labelled principles as health and pharmacy professionals' right to the conscientious objection on the one hand and, on the other hand, a series of reproductive and sexual health-related values and human rights. The findings for the Polish sample ($N=121$) examined in this paper reflect the complex normative situation of a society seeking a balance and consensus between traditional, e.g., predominantly Christian values with their claims to universal validity and the plurality of values and principles. Persons and professionals unable to recognize and accept this plurality (which might be demanding due to the moral competence level, regardless of particular moral affiliations, opinions, and attitudes) are prone to 'unresolvable' conflicts and may potentially violate fellow citizens' human and legal rights – as contraception in Poland belongs to the legal medical services.

Our study demonstrated that a quiet high moral competence (though experimentally scored for one dilemma only) may correlate with various and even dichotomous preferences on contraception use among its female purchasers in Poland. In contrast, low moral competence would produce a normative trap for all citizens, including health and pharmacy professionals, patients, their relatives, and society as a whole. If pharmacists (and, generally, all health professions) are eligible to prioritize their moral conscience clause over their fellow citizens' human and legal rights, and yet were unable to find a balance, and to respect fellow citizens' rights and values (without resigning from conscience protection), this could permanently stir up conflicts and painful dilemmas between conscience clause, obligations to patients, and patient rights (Drozd 2013; Flynn 2008). This also would increase discomfort in society, due to violation of the legal, human, and fundamental rights of purchasers who need contraceptives for health-related purposes; would sharpen social inequalities, violate democratic difference and principle pluralism, and postpone public discourse or deliberation, which are needed to elaborate reasonable consensus or reasonable dissensus on choice-friendly laws. Enabling and empowering future health and pharmacy professionals to provide patients with medicinal products in just and fair way (Yoder 2007) beyond particularisms and biases would be one of the priorities of medical education.

Public axiologies are dynamic spheres, especially in societies in transition from

nondemocratic to democratic constitutions. Polish society has been in democratic transition since 1989, with various effects. For instance,

the immediate postsocialist period between 1989 and 1993, strongly influenced by Catholic nationalism, brought critical transformations in policies regulating reproductive and sexual health and rights (...). Of particular importance in regulating reproductive and sexual conduct was the implementation of the Conscience Clause law. The clause, written into the postsocialist Medical Code of Ethics in 1991, provides that 'a physician can withhold health services which are not in agreement with his conscience', but must make a referral elsewhere where there are 'realistic possibilities of obtaining such a healthcare' (Mishtal 2009, 163).

Thirty years later, women have difficulty not only in exercising their right to abortions in cases permitted by law (Mishtal 2009, 171), but also in exercising their right to obtain legal contraceptives, both due to the health providers' conscience clause and because there is a lack of respect for their conscience and their rights. Twenty years after Mishtal's research, pharmacists and gynecologists continue to declare, "here in our clinic we absolutely do not condone contraception, because those are the rules of how we provide care," and so they follow their particular "contraceptive conscience," as one of Mishtal's interviewees admitted (Mishtal 2009, 173).

Democracy, as a set of public institutions and procedures, such as deliberative and discursive, is a permanent project everywhere. In Eastern Europe, the grassroots, axiological, and normative self-constitutionalization of societies after 1989 occurs not only in the public spheres but also much more profoundly. It might be an antagonistic process in all political cultures, including mature democracies, when individuals, professionals, or citizens contest values they do not prioritize for themselves (Bozeman 2018; Ogorevc et al. 2019). However, axiological particularities and polarities should not discredit public institutions and human and fundamental rights, including those concerning health and health care. The latter show increasing complexity and specificity in line with advances in health sciences, including pharmacology, and, finally, due to the progressive recognition of autonomous self-determination and rights of groups previously controlled by other groups and power centers (Gyrd-Hansen 2004). The European Parliament resolution on the 25th anniversary of the International Conference on Population and Development (ICPD25) (Nairobi Summit) was voted on June 25, 2021. Among others, the resolution shall urge the EU member states to improve women's "control over their bodies, their health, and their fertility," their ability „to define their role in society if sustainable growth and development are to follow such steep population growth," and their access to "comprehensive reproductive healthcare," "contraception and emerging contraceptive methods" (European Parliament 2021). Arguably, the progress in medicine seems to be ahead of the normative development of societies, especially those familiar with more traditional values: to this day, one can still hear public complaints voiced by religious authorities about the availability of oral contraception, in vitro fertilization technology, prenatal and preimplantation diagnostics discovered decades ago.

In the face of the differentiation and antagonization of priorities and values, the “legitimation crisis” (Habermas 1988) is also intensifying, which means that it is not the values but the principles that allow the balance of different, sometimes opposite values in parallel. Recognizing such a balance would be the first deal essential for democratization. However, ensuring a multitude of values through general principles is not enough. Improving institutional (instead of particular) “public value governance” (Huijbregts et al. 2022) and fostering professionals’ ability to manage this plurality in everyday practice of common and public institutions such as public health care would be the second deal that is essential for democratization. This ability corresponds to a well-developed moral competence (e.g., Lind 2012) and “principled judgment” as its core performance.

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